

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16752

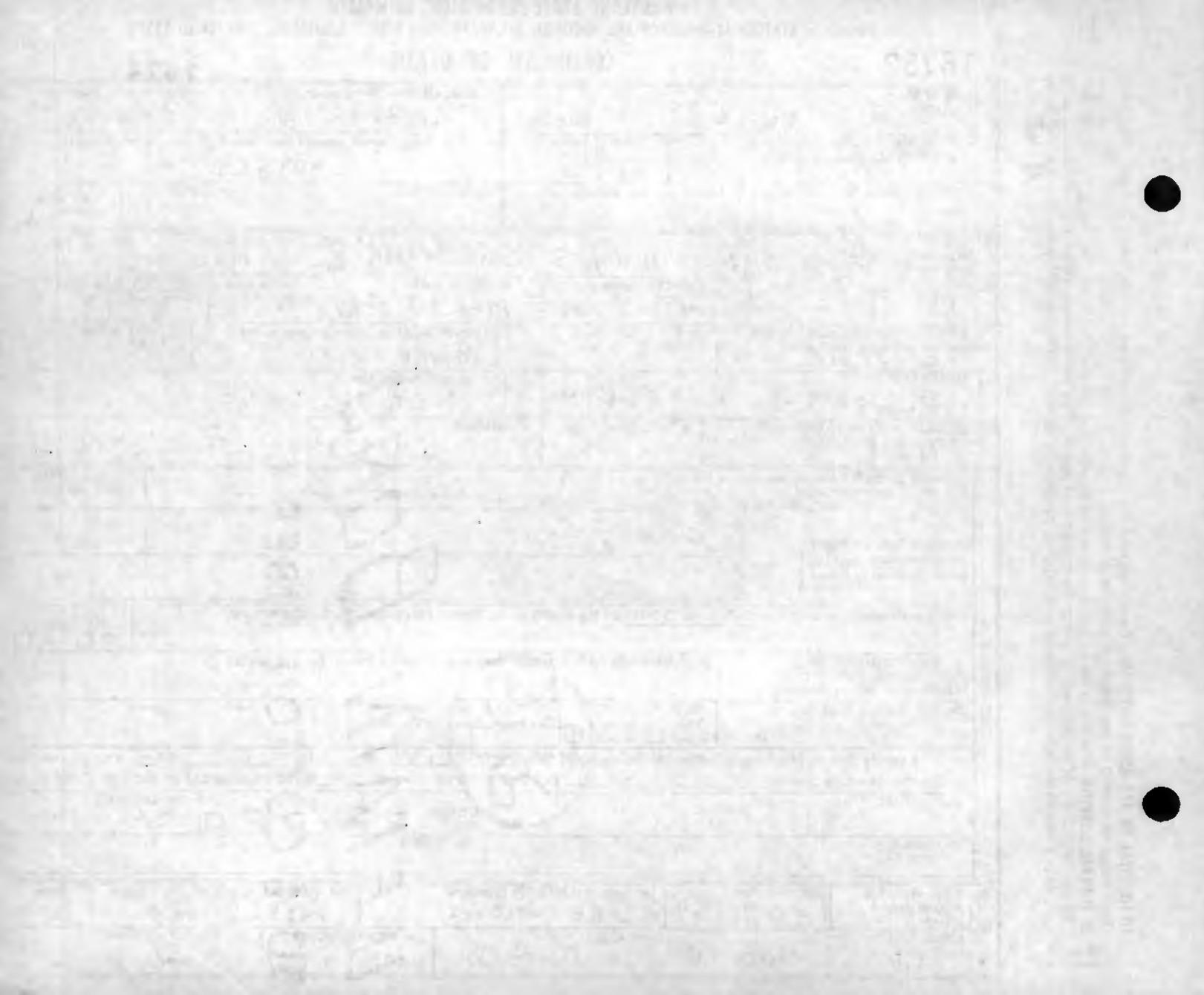
CERTIFICATE OF DEATH

16747

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY		c. LENGTH OF STAY IN 1b LDFB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY	
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM DENNIS BENEBRINK		First WILLIAM	Middle DENNIS
4. DATE OF DEATH Month DEC		Day 6	Year 1967
5. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH MAR 17, 1889
9. AGE (In years birthday) 78	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM J. BENEBRINK	14. MOTHER'S MAIDEN NAME NORA LANE	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT MRS. W.M. BENEBRINK, RIDGELEY	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior teeth / Dent Disease			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Decompensate			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6130/67
20f. (City or town) HILLSBORO		(County) MARYLAND	(State) MD.
21. I certify that (I) (this hospital) attended the deceased from 6/30/67 to 11/20 , 1967, that (I) (we) last saw the deceased alive on 11/20/67 , and that death occurred at 10:00 M, from causes and on the date stated above.		22b. DATE SIGNED 12/1/67	
22a. SIGNATURE P. H. / P. D. Palmer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec 9, 1967	23c. NAME OF CEMETERY OR CREMATORIAL GREENMOANT
23d. LOCATION (City or Town) HILLSBORO		(County) MARYLAND	(State) MD.
24. FUNERAL DIRECTOR VIRGIL MOORE		ADDRESS DENTON MD.	25a. RECD BY REGISTRAR DATE DEC 12 1967
25b. REGISTRAR'S SIGNATURE Charles Judge			



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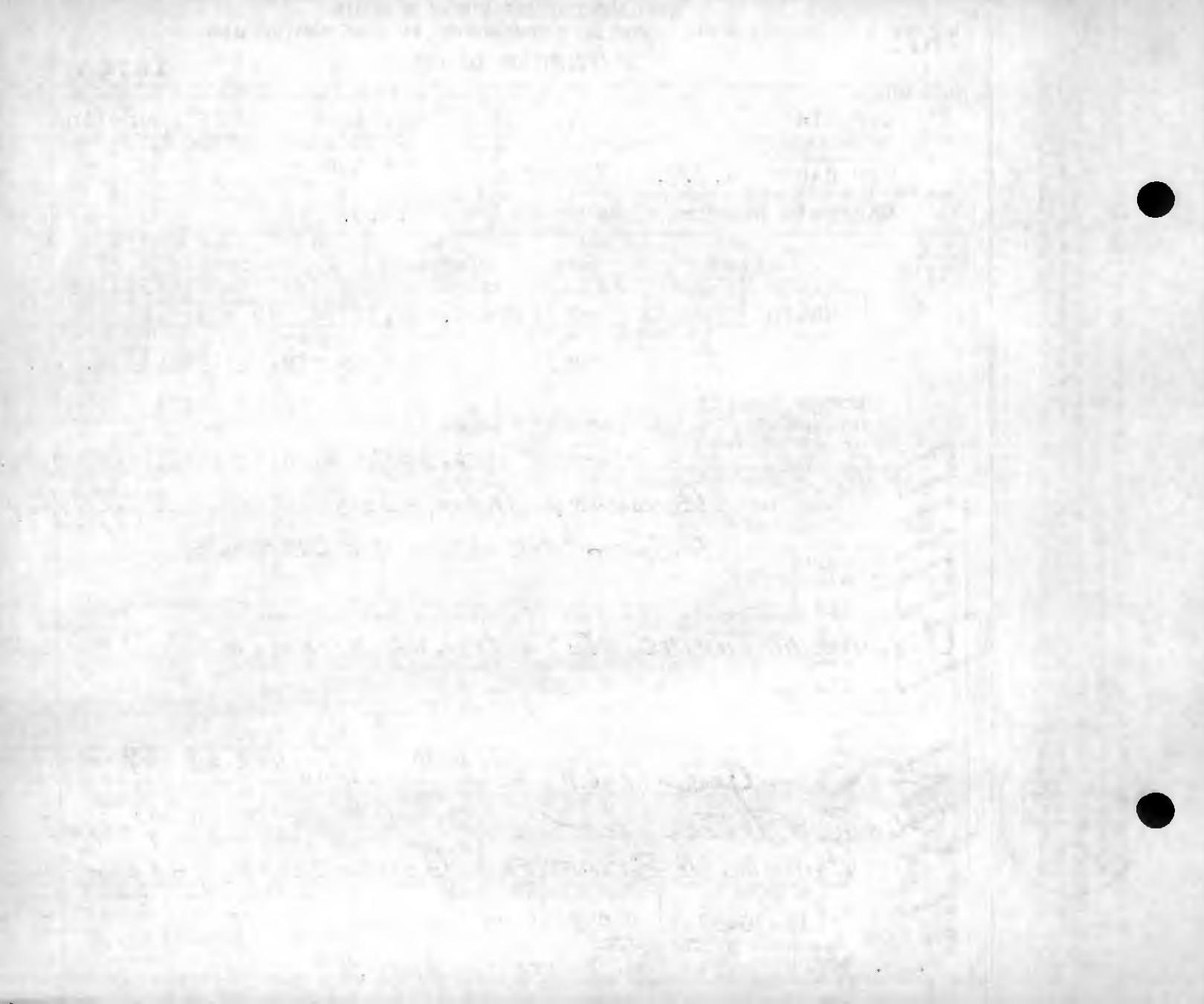
CERTIFICATE OF DEATH

16748

10 HOSPITAL OR ATTENDING PHYSICIAN: the law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH o. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro R.F.D.		c. LENGTH OF STAY IN 1b 7 Months	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		e. STREET ADDRESS R.F.D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry's Nursing Home		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Mae Johnson		4. DATE OF DEATH December 27 1967	Month Doy Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 20, 1879		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (County & State, or foreign country) Sussex County, Delaware U.S.A.	
13. FATHER'S NAME George Truitt		14. MOTHER'S MAIDEN NAME Annie Betts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-7323	
17. INFORMANT Mrs. Marie S. Hilprect, Preston, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ARTERIOSCLEROTIC C.V. DISEASE DUE TO last (c)		INTERVAL BETWEEN ONSET AND DEATH 12/27/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC ARTHRITIS. NOT TRANSITIONAL ANEMIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Seaford
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 10 1967 , to DEC 27 1967 , that (I) (we) last saw the deceased alive on Dec 27 1967 , and that death occurred at 10 AM , from causes and on the date stated above.		22b. DATE SIGNED 12/28/67	
22c. SIGNATURE Charles H. Stowersifer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS GREENSBORO, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-67	23c. NAME OF CEMETERY OR CREMATORIAL Old Fellows Cemetery
23d. LOCATION (City or Town) Seaford		(County) Sussex Del.	(State)
24. FUNERAL DIRECTOR Margaret H. Frampton		ADDRESS J. J. Frampton and Son, Federalsburg, Md.	25a. REC'D BY REGISTRAR DATE JAN 2 1968
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16754

CERTIFICATE OF DEATH

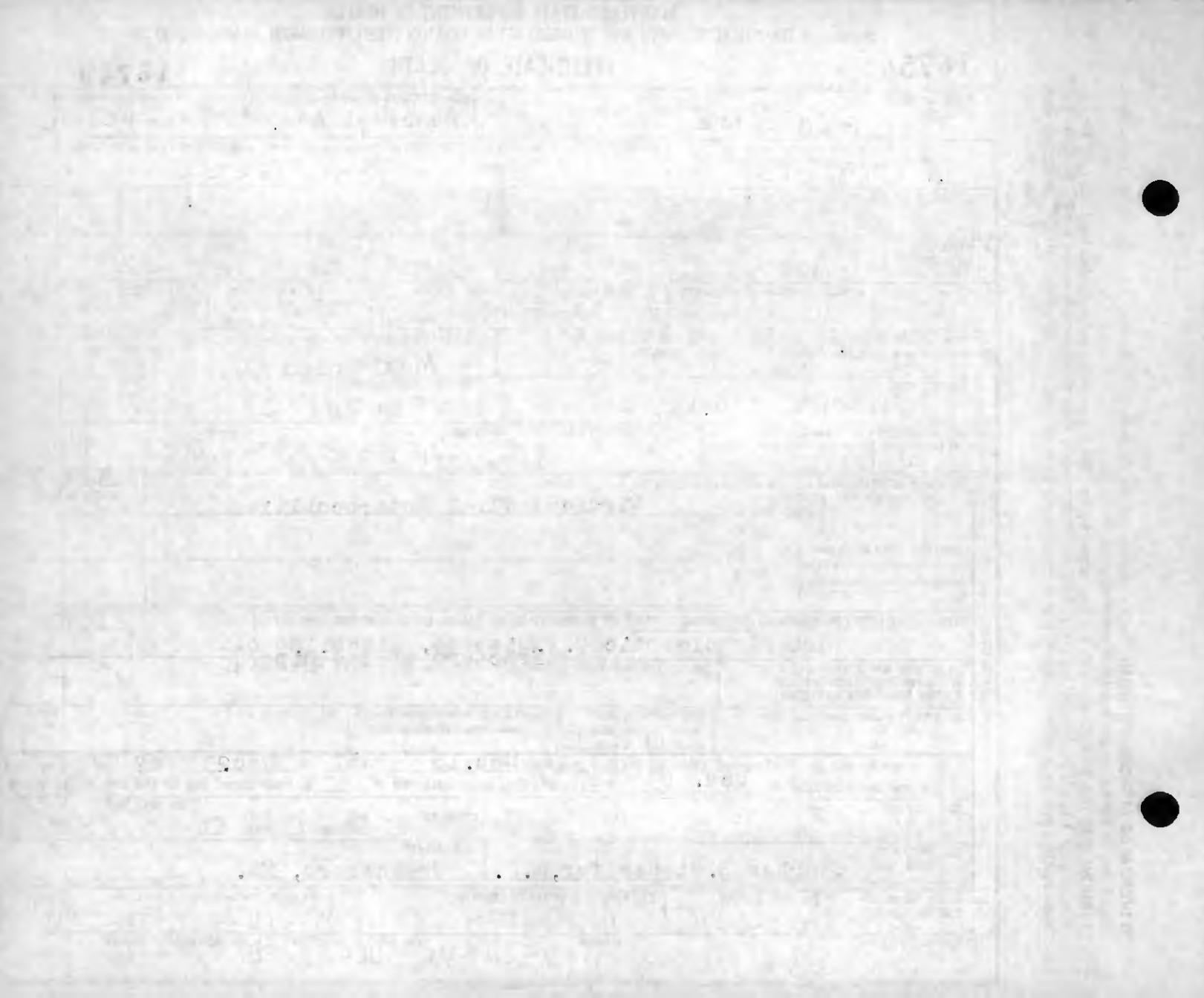
16749

1. PLACE OF DEATH a. COUNTY CAROLINIE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ANNIE TODD SAMIS		First	Middle			
4. DATE OF DEATH Month Dec		Year 1967	Day 23			
S. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH May 26, 1875		9. AGE (In years last birthday) 92 yrs.				
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				
13. FATHER'S NAME JAMES MASON		12. CITIZEN OF WHAT COUNTRY USA				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.				
17. INFORMANT MRS. PAGE JONES, RIDGELEY MD.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virulent Viral Enterocolitis						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic C.V. Disease, Disabling old						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 1b.) In the course of his/her				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Dec. 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) in the home	20f. (City or town) Dec. 23, 1967	(County) MD.	(State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1967 , to Dec 23, 1967 , that (I) (we) last saw the deceased alive on Dec. 23, 1967 , and that death occurred at MD. from causes and on the date stated above.						
22a. SIGNATURE Charles H. Stonesifer		M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED 12/26/67
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 26, 1967		23c. NAME OF CEMETERY OR CREMATORIAL RIDGELEY		23d. LOCATION (City or Town) RIDGELEY
24. FUNERAL DIRECTOR Charles H. Moore Denton MD.		ADDRESS		25a. RECD. BY REGISTRAR DATE DEC 29 1967		25b. REGISTRAR'S SIGNATURE Charles Moore

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNDERTAKEN FOR THE USE OF THE BURIAL-FRANCHISER ONLY. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A circular library stamp containing the letter 'M' at the top and the number '2' at the bottom.

16755

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY		Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. LENGTH OF STAY IN 16 94 Yrs.		o. STATE Maryland b. COUNTY Caroline	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		f. STREET ADDRESS None	
g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida		First	Middle	Last	4. DATE OF DEATH 12-26-1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 9-8-1873	9. AGE (In years last birthday) 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Richard Schuyler		14. MOTHER'S MAIDEN NAME Matilda Hughes		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edward Schuyler Henderson, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO } (c) DUE TO		Generalized Arteriosclerosis			
		Malnutrition and Nutritional Anemia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Greensboro	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 , to Dec. 26, 1967 that (I) (we) last saw the deceased alive on Dec. 26, 1967 , and that death occurred at M , from causes and on the date stated above					
22a. SIGNATURE Charles H. Stonesifer		22b. DATE SIGNED Dec. 28, 1967			
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greensboro	23d. LOCATION (City or Town) Greensboro, Maryland	(County) (State)
24. FUNERAL DIRECTOR J. E. Boulaire		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be loaned to the Chief Medical Examiner's Office along with form PMAs. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.
16756

MARYLAND STATE DEPARTMENT OF HUMAN RESOURCES BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

16751

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston, Md. RFD.		c. LENGTH OF STAY IN 1b 37 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas M. Wood		First Thomas	Middle M.
4. DATE OF DEATH Dec. 10, 1967	Month Dec.	Day 10	Year 1967
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1917
9. AGE (In years from birth) 50 yrs.	10. IF UNDER 1YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY bldg. supply co.	11. BIRTHPLACE (State or foreign country) Boston, Mass.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert T. Wood		14. MOTHER'S MAIDEN NAME Cora Fuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Mary Jane Wood		Address Preston, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vacular Accident Probaly Hemorrhage minutes			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive arteriosclerotic Hardening of brain 75 yrs			
Disease			
DUE TO (b) Generalized arteriosclerosis severe for age 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?full mental capacity mental age of about 12 yrs			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Harold B. Plummer</i>		DATE SIGNED 12/12/67	
EXAMINER'S NAME (Type) Harold B. Plummer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Caroline Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/13/67	
22c. NAME OF CEMETERY OR CREMATORIUM Bloomery Cem.		22d. LOCATION (City, town, or county) (State) Federalsburg, Md. RFD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Morrison</i>		24a. REC'D BY REGISTRAR ADDRESS Federalsburg, Md.	
		24b. REGISTRAR'S SIGNATURE DATE DEC 15 1967 <i>Charles Judge</i>	

